Arizona Medical Board

9545 East Doubletree Ranch Road • Scottsdale, Arizona 85258
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DRAFT MINUTES FOR EMERGENCY SUMMARY ACTION MEETING
Held at 5:30 p.m. on Tuesday July 10, 2007
9545 E. Doubletree Ranch Road · Scottsdale, Arizona 85258

Board Members

William R. Martin III, M.D., Chair
Douglas D. Lee, M.D., Vice Chair
Dona Pardo, Ph.D., R.N., Secretary
Dan Eckstrom
Robert P. Goldfarb, M.D., F.A.C.S.
Patricia R.J. Griffen
Ram R. Krishna, M.D.
Todd A. Lefkowitz, M.D.
Lorraine L. Mackstaller, M.D.
Paul M. Petelin Sr., M.D.
Germaine Proulx
Amy J. Schneider, M.D., F.A.C.O.G..

CALL TO ORDER
The meeting was called to order at 5:30 pm.

ROLL CALL
The following Board Members were present: Dr. Goldfarb, Ms. Griffen, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Pardo, Dr. Petelin, Ms. Proulx and Dr. Schneider. The following Board Members were absent: Mr. Eckstrom and Dr. Krishna.

CALL TO THE PUBLIC
Statement issued during the call to the public will appear beneath the case referenced.

TIME SPECIFIC MATTER					
NO.	**CASE NO.**	**COMPLAINANT v PHYSICIAN**		**LIC. #**	**RESOLUTION**
1.	MD-07-0328A MD-07-0589A	AMB AMB	PETER JAMES NORMANN, M.D.	33254	Summary Suspension

Vicki Johansen, Case Manager, presented the matter to the Board. Two patients, RJ and AS, suffered cardiac arrest and died after undergoing liposuction procedures in Dr. Normann's office. Shortly after the investigation (MD-07-0328A) involving these two patients was opened, Dr. Normann entered into an Interim Practice Restriction prohibiting him from performing any office procedures, surgeries, or use of conscious sedation. The Outside Medical Consultant (OMC) reviewed the records for RJ and AS, as well as other patient records, and found Dr. Normann had a high complication rate of 75%, his medical records were abysmally inadequate with missing operative reports, illegible handwritten and often unsigned notes, and no history and physical noted for RG. The OMC found AS and RG did not die as a result of a tragic mistake, but from failure in multiple aspects of the standard of care in the proper use of Propofol in conscious sedation. Additionally, Dr. Normann demonstrated patterns of failure in modern medicine and patient safety including inadequate record keeping and documentation; lack of informed consent; hiring unqualified personnel, including a license massage therapist, a former restaurant owner, two former pre-school teachers and his mother; improperly supervising personnel, improper pre-operative patient evaluation and more. Dr. Normann allowed unlicensed staff to practice medicine by allowing a massage therapist to perform liposuction, suture, and monitor patients postoperatively while he was out of the country. Additionally, Dr. Normann provided false or misleading information to Board Staff by referring to his employees as medical assistants in his operative records.

After Dr. Normann entered into the Interim Practice Restriction he then entered into an agreement with a homeopathic physician, Gary Page, to assist and perform surgical procedures. On July 9, 2007 the Board received notice of a third patient death, LW, after Dr. Page performed a thigh liposuction procedure.

Dr. Normann addressed the Board. He stated he would like the ability to show the Board he is a competent physician at some time in the future.

Carol Peairs, M.D., Medical Consultant, stated LW's death is very concerning because she was admitted to Dr. Normann's facility for liposuction of the thighs, a one hour procedure. Dr. Page, who is not a licensed allopathic physician, spent six hours performing the procedure. Dr. Normann took over in the postoperative period and there is no indication that he monitored LW other than to sit with her while she waited for a ride. LW could not be aroused, she became apnic and she died. In case MD-07-0328A, one patient suffered cardiac arrest prior to the procedure and the other patient arrested during the procedure. Dr. Peairs stated Dr. Normann demonstrated abysmal judgment with these three patients.

Dr. Martin inquired about the timing of the Interim Consent Agreement for Practice Restriction in relation to the patient deaths. Ms. Johansen stated that Dr. Normann entered into the Interim Consent Agreement during the course of the investigation into patients RG and AS. The second case involving LW was received by the Board yesterday morning. The third patient death, in combination with the two previous deaths, raised the concern to a summary action.

Dr. Goldfarb stated Dr. Normann has been practicing in an unsafe manner, has a high complication rate, including three patient deaths, and demonstrated failures in almost every area of practice.

MOTION: Dr. Goldfarb moved to summarily suspend Dr. Normann's license based on an imminent threat to public health and safety.
SECONDED: Dr. Petelin
ROLL CALL VOTE: Roll call vote was taken and the following Board Members were in favor of the motion: Dr. Goldfarb, Ms. Griffen, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Pardo, Dr. Petelin, Ms. Proulx and Dr. Schneider. The following Board Members were absent: Mr. Eckstrom and Dr. Krishna.
VOTE: 10-0-2

The meeting adjourned at 5:45 p.m.

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Timothy C. Miller, J.D., Executive Director